MIAMI – DADE COUNTY / JACKSON HEALTH SYSTEM
Transition-of-Care Form For AvMed Members utilizing Beech Street Providers

AvMed SELF-FUNDED OPTIONS

AvMed Health Plans ● Fax 1-800-552-8633 ● Member Services 1-800-682-8633

If you require assistance with transition of your medical service from your current health plan or if you are currently using a Beech Street provider, please complete this form and fax to 1-800-552-8633. This information is NOT used to determine eligibility – it is to assist in arranging a smooth transition of your medical care to AvMed providers. In certain circumstances, you may be able to continue treatment with your current physician. To assure coverage, any planned or on-going treatment must be coordinated and approved by AvMed prior to services being rendered**.**

Please complete this form for each person in your family that requires Transition of Care.

Employee SS#: _____- _____ - _____

Member Information

Member last name	First name	MI	Date of birth:
Street address	City	State	ZIP code:

Work phone #:	Home phone #:	Today's date:	Social Security #:
Relationship to employee: Spouse - Child - Other	AvMed Member #:	Beech Street Provider	Beech Street Provider phone #:

I. Ongoing medical treatment:

Current active chemotherapy/radiation ☐ Previous chemotherapy/radiation/dialysis☐ Transplant ☐ Dialysis ☐

Congestive heart failure ☐ Asthma ☐ Diabetes ☐ Open wound ☐ Other: ☐ (Please describe)_____

II. Are you pregnant? ☐Yes ☐ No High-risk pregnancy? ☐Yes ☐No

Due date:	Obstetrician:	Physician phone #:	At which hospital do you plan to deliver:

Any complications during your pregnancy? If yes, please specify. ☐Yes (examples: high blood pressure, thyroid problems, diabetes) ☐ No

III. Other:

I AUTHORIZE any licensed physician, hospital, clinic or other related facility or provider to release for review my or my enrolled dependent children's (under age 18) medical records to AvMed Health Plans. This authorization includes psychiatric and substance abuse records as well as concurrent inpatient review. By signing this form, you consent to our use and disclosure of protected health information about you or your dependent children for treatment, payment and health care operations.

_____ _____

Member Signature (REQUIRED) Date

*If AvMed has not contacted you within 14 days of submission of form, please call 1-800-682-8633.